DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POC accepted Letter sent 1/22/07 B. Clausen

PRINTED: 01/03/2007
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295079	A. BUILDING _____ B. WING _____	C 01/03/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN MOUNTAINVIEW HEALTH	201 KOONTZ LANE CARSON CITY, NV 89701

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as the result of a complaint investigation conducted at your facility on 12/13/06. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil actions or other claims for relief that may be available to any party under applicable federal, state or local laws. Complaint #NV00013751 was a self reported incident of an injury of unknown origin. The complaint was substantiated with deficiencies cited at F225 and F279.	F 000	MAILED JAN 22 2007 DISCLAIMER CLAUSE PREPARATION AND/OR EXECUTION OF THIS PLAN OF CORRECTION DOES NOT CONSTITUTE THE PROVIDER'S ADMISSION OF OR AGREEMENT WITH THE FACTS ALLEGED OR CONCLUSIONS SET FORTH IN THE STATEMENT OF DEFICIENCIES. THE PLAN OF CORRECTION IS PREPARED AND/OR EXECUTED SOLELY BECAUSE IT IS REQUIRED BY THE PROVISIONS OF FEDERAL AND STATE LAW. Bureau of Licensure and Certification Carson City, Nevada RECEIVED JAN 19 2007 BUREAU OF LICENSURE AND CERTIFICATION CARSON CITY, NEVADA	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225	F225 **A formal investigation has been completed with regard to the fracture and the bruises on Resident #1. As indicated, the fracture appears to be chronic. The exact cause of the bruising remains undetermined, although the Nursing staff feels that the leg bruises were caused by rubbing on the wheelchair. The resident remains in the building and is doing well. The bruises are almost healed. The fracture, while chronic, is having minimal effect on the resident.** **No additional residents were affected by this deficient practice.** 1-19-07 **C.N.A.'s will receive training on proper lifting techniques and the importance of immediately reporting bruises and any other change of condition and/or evidence of injury. Licensed Nursing staff will receive training concerning the facility policy of investigating all injuries of unknown origin including bruises.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	RON PETERSEN ADMINISTRATOR	1-19-07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation, it was determined that the facility failed to follow the facility's abuse and neglect policy and procedure in order to ensure that 1 of 1 residents was not abused or neglected. (#1) Findings include: Resident #1: The resident was admitted to the facility on 5/7/05, with diagnoses including vascular dementia, congestive heart failure, pleural effusion, urinary tract infection and depressive disorder. Record review of 1/3/07, revealed that she was 95 years old and unable to be interviewed due to confusion. Her minimum data set (MDS) dated 11/13/06, indicated her cognitive skills were severely impaired and she was unable to make decisions. An interdisciplinary progress note written at 6:30 AM on 12/26/06, indicated that the resident was found to have three bruises on the right side of	F 225	**Medical Records will conduct periodic audits to ensure that all incidents and injuries of unknown origin are investigated and reported according to facility policy and regulatory requirements.** **The DON will be responsible to ensure that all injuries of unknown origin are investigated and reported.** **The Administrator is responsible for completing investigations and reporting when abuse is suspected, indicated, or alleged.** 2-8-07	

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F 225	Continued From page 2 her body. A bruise with faded edges measuring six inches by three inches was found on her right lower extremity. A "faded" bruise measuring two inches was found on her right breast. Her right shoulder, biceps area and under arm were noted to have a substantial bruise which was noted to be changing color around the edges. The notes indicated that at 10:30 AM, the shoulder bruise was measured and found to be five inches by seven inches. It was described as being dark red with a yellow border. The resident was described as having "some" signs and symptoms of pain when the arm was moved. The physician and the resident's daughter and power of attorney (POA) were notified of the of the bruises. The physician ordered an X-ray of the right arm which revealed a fracture of the proximal humerus. The X-ray report indicated the fracture appeared to be chronic. The resident was seen by an orthopaedic physician who indicated she had an old right proximal humerus fracture and recommended a sling. On 12/29/06, the attending physician's notes indicated that the cause of the fracture was unknown but the physician noted that the resident had fallen out of bed several times. His note also indicated the resident had a chronic fracture of the humerus. On 1/3/07, at 10:20 AM, the administrator and the director of nurses were interviewed. The director of nurses (DON) indicated that the fracture was determined to be old and chronic. The cause of the fracture and the bruising was reported to be unknown. She did not know if there was any history of a prior injury to the right arm. She stated that there were no reports of a recent fall	F 225		

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F 225	Continued From page 3 by the resident. She stated that she thought the leg bruise may have been caused by the resident's wheel chair. The DON reported that licensed practical nurse (LPN) #1 had spoken to several certified nursing assistants (CNA's) who were on shift at the time the bruising was discovered. She reported that no formal investigation of the injuries had been conducted. On 1/3/07 at 1:30 PM, resident care manager #1 (RCM) was interviewed. She did not know the origin of the resident's bruises or fracture. She reported that the resident was found out of bed on the floor on 8/15/06 but the resident had no reported falls since that time. She reported that the resident was placed in a special bed and mattress to prevent falls following that incident. RCM #1 reported that the leg bruise might have been caused by the resident's leg rubbing against the wheelchair and the upper extremity bruise might have been caused by an employee using improper lifting techniques. She did not know of a formal investigation of the bruises or fracture and did not know who the facility's abuse coordinator was. On 1/3/06 at 1:45 PM, the resident was observed. She had a small fading brown bruise measuring approximately 2 inches in the right axillary area. No marks were found on the right breast. A yellow area of discoloration was noted on the right shoulder. The resident was found to be in a special bed and mattress as indicated in her care plan with her bed in the lowest position. A pad was in place on the floor beside her bed.	F 225		

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F 225	Continued From page 4 On 1/3/07, the facility's Abuse, Neglect and Misappropriation of Resident Property Prohibition policy was reviewed. The policy was effective in February 2000 and was last revised on April 2005. The policy defined an injury of unknown source as follows: "Injuries of unknown source means when the source of the injury was not observed by any person or the source of injury could not be explained by the resident; and the injury is suspicious because of the extent or the location of the injury or the number of injuries observed at one particular point in time or incidence of injuries over time." The policy also indicated that the facility conducted a thorough investigation of allegations of mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property in accordance with state and federal regulation. The policy indicated that soft tissue injuries of unknown origin were to be investigated. The policy further revealed that the facility reported investigative findings to the state survey and certification agency and appropriate state agency per state regulation within five working days of the event. On 1/3/07, at approximately 12:10 PM, the DON was again interviewed. She presented an untitled list of staff names. Eight of the names had checks beside them. The DON reported that LPN #1 had spoken to these staff members to see if they knew anything about Resident #1's injuries. She was unable to provide documentation of the staff responses or written statements from the staff who were spoken to. She confirmed that no formal investigation was conducted, therefore, no	F 225		

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F 225	Continued From page 5 investigation report was submitted to the Bureau of Licensure and Certification (BLC) within the five day time frame. The DON was asked the name of the facility's abuse coordinator. She stated that the facility did not have an abuse coordinator. At 3:20 PM, on 1/3/07, the facility administrator was asked who the abuse coordinator was and he indicated that the DON was the facility abuse coordinator. The DON was not aware that she was responsible for investigating injuries of unknown origin and submitting the findings to BLC as per the facility's policy.	F 225		
F 279 SS=D	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F279** **Resident #1 is doing well. The chronic fracture has been addressed in her care plan and care giving staff has been instructed concerning how to accommodate this injury. The bruising on her leg has also been included in the care plan with our ongoing practice of using a pillow to give padding and protection from rubbing on the wheelchair listed as an approach.** **All residents have the potential to be affected by this deficient practice. An audit of care plans has not disclosed any that have actually been affected.** 1-19-07 **Licensed nursing staff will be given training about the importance of care planning all resident need and changes of condition. Special attention will be given to the issues of bruising from medical devices and the care of conditions such as fractures. This training will also stress the importance of ensuring that all care giving staff including C.N.A.'s are instructed on special resident care needs.**	

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F 279	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation it was determined that the facility failed to review and revise the comprehensive care plan for 1 of 1 resident. (#1) Findings include: Resident #1: The resident was admitted to the facility on 5/7/05, with diagnoses including vascular dementia, congestive heart failure, pleural effusion,urinary tract infection and depressive disorder. Record review of 1/3/07, revealed that she was 95 years old and unable to be interviewed due to confusion. Her minimum data set (MDS) dated 11/13/06, indicated her cognitive skills were severely impaired and she was unable to make decisions. An interdisciplinary progress note written at 6:30 AM on 12/26/06, indicated that the resident was found to have three bruises on the right side of her body. A bruise with faded edges measuring six inches by three inches was found on her right lower extremity. A "faded" bruise measuring two inches was found on her right breast. Her right shoulder, biceps and under arm were noted to have a substantial bruise which was noted to be changing color around the edges. The notes indicated that at 10:30 AM, the shoulder bruise was measured and found to be five inches by seven inches. It was described as being dark red with a yellow border. The resident was described as having "some" signs and symptoms of pain when the arm was moved. The physician and the resident's daughter and power of attorney (POA) were notified of the of	F 279	**Resident Care Managers (R.C.M's) are responsible to ensure that care plans are completed and comprehensive. Director of Staff Development is responsible for training of Nurses and C.N.A.'s. Care plans will be periodically audited by D.O.N. and facility consultants from various disciplines to ensure that they address all relevant resident care issues. They will submit reports which will be evaluated by the CQI Committee for additional recommendations.** 2-8-07	

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F 279	Continued From page 7 the bruises. The physician ordered an X-ray of the right arm which revealed a fracture of the proximal humerus. The X-ray report indicated the fracture appeared to be chronic. The resident was seen by an orthopaedic physician who indicated she had an old right proximal humerus fracture and recommended a sling. On 12/29/06, the attending physician's notes indicated that the cause of the fracture was unknown but the physician noted that the resident had fallen out of bed several times. His note also indicated the resident had a chronic fracture of the humerus. On 1/3/07, at approximately 1:30 PM, resident care manager #1 (RCM) was interviewed. She did not know the origin of the resident's bruises or fracture. She reported that the resident's bruises could have been caused from a fall from bed and that she becomes active at times during the night. She stated that no falls had been reported since 8/15/06. RCM #1 stated that the right leg bruise could have been caused by the resident's leg rubbing against the wheelchair. She reported that the physician ordered a sling for the resident's right arm. She also stated that the arm bruise might have been caused by staff using inappropriate transfer techniques. Review of the resident's care plan revealed no mention of the resident's fracture or special precautions to be taken to prevent further injury. The resident's ordered use of a right arm sling was not mentioned in the care plan. Although bruising was identified as a problem, no mention was made regarding the use of special pads to	F 279		

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F 279	Continued From page 8 prevent bruising of the resident's leg. Records revealed no reassessment or change in approach to resident transfers. RCM #1 confirmed that the care plan had not been revised to identify the resident's fracture as a problem. No changes were made in the care plan to identify special precautions taken when handling the resident's arm or transferring the resident. On 1/3/07 at approximately 1:40 PM, CNA #1 was interviewed. She was assigned to care for the resident during the day shift. She stated that she was aware of the resident's right arm fracture and knew she needed a right arm sling. She did not know of any other special precautions to be taken with the resident but knew she must be gentle when handling her arm or transferring her. On 1/3/07, at approximately 3:10 PM, CNA #2 was interviewed. She was assigned to provide care to the resident during the evening shift. She stated that she thought the resident's arm had been sprained and that she needed a sling to her right arm. She did not know of any special precautions to be taken with the resident. She stated that she had already taken shift report.	F 279		